Prior Authorization

MIHS-HP' Medical Management Authorization Unit determines in advance the medical appropriateness of a requested medical services and whether or not the service will be covered for payment based on the initial information received. The authorization may be given by telephone or fax and is given in **advance** of the performance of services.

Prior Authorization for services covered by MIHS-HP plans are issued within certain limitations based on the following:

- The member is eligible with MIHS-HP at the time of request (may be confirmed on-line)
- Provider is contracted or approved by MIHS-HP to provide services. Secondary status as an AHCCCS registered FFS provider
- Requested service is an MIHS-HP plan benefit
- Information received meets the requirements for issuing a prior authorization
- Requested service is not covered by another payor (e.g., commercial insurance, Medicare, etc.). *NOTE: Determination will be made based on information from the provider and by reviewing the member file.*

An after business hour request for authorization must be made through the 24-hour authorization unit at 602/344-8111.

The Authorization number provides access to the MIHS-HP automated claims processing system and ***does not guarantee payment.*** MIHS-HP reserves the right to request medical records and/or other documentation to substantiate any charges billed to the agency. Payment is based upon member eligibility at the time of service and substantiating documentation of appropriateness of the care, service, or treatment. If the claim and documentation review fails to establish medical necessity and/or appropriateness of the care, service, or treatment payment will be denied.

Prior authorization referrals that do not meet the established criteria for medical necessity or are not a covered benefit, will be forwarded for approval/denial to Medical Management.

MIHS-HP will complete prior authorization of referrals within 24 hours on an emergency request, 48 hours on an urgent request, and five (5) working days for routine requests that contain all necessary information. ***Emergency services do not require "prior" authorization***. In an emergency, providers are authorized to administer immediate stabilizing treatment and are required to call the MIHS-HP Authorization Unit when the member has been stabilized.

MSSP members have direct access (through self-referral) for mammography, influenza vaccine and pnuemococcal vaccine. Women may choose direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits while the plan maintains a PCP or some other means for continuity of care.

Specialty Referrals

Specialty referrals are to be directed to MIHS-HP network specialists. If an MIHS-HP patient requires care outside the MIHS-HP network, prior authorization must be obtained from MIHS-HP. Appointments must be coordinated through the PCPs office by calling the appointment desk at 602/344-1015.

Prior Authorization cont.

Behavioral health services are coordinated through the PCPs office (please refer to Section 3 – PCP Responsibilities and Section 19 – Behavioral Health of the manual). The management of psychotropic medications and the role of the PCP are included in the Behavioral Health Section, as well.

MSSP Members

MIHS-HP is responsible for the cost of post stabilization care provided outside the plan for MSSP members if:

- Care was pre-approved by MIHS-HP, or
- Care was not pre-approved, because MIHS-HP did not respond to the provider of post stabilization care services request for pre-approval within one (1) hour after being requested to approve such care, or could not be contacted for pre-approval
- MIHS-HP must provide coverage for all services that are covered by Part A and Part B of Medicare. MIHS-HP must also comply with HCFA's national coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area where services are covered under the Medicare + Choice plan

The 24-hour Authorization Unit has licensed registered nurses available 365 days a year and 24 hours a day to answer provider questions (not an advice line) and provider authorizations for urgent situations. Access to the 24-hour line is available to request authorizations for medically necessary care and services. MIHS-HP authorization staff has access to a physician when necessary to make determinations regarding prior authorizations. Calls to the Authorization Unit will be recorded and reviewed to ensure that procedures are followed properly, as well as serving to clarify questions that may arise regarding the provider's request and what was authorized.

MIHS-HP requires its contracted providers to obtain prior authorization for many covered services based on specific plan benefits. Please use the list below to identify the appropriate contact phone number for the services being requested. To request prior authorization for a referral and/or service, please utilize the following numbers:

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Prior Authorization cont.

Prior Authorization

Service or Procedure	Phone Number	Fax Number
After Hours Authorizations	344-8111	344-8458
Hospitalization Requests/Notifications: Inpatient hospitalizations Pre-admissions day before surgery Observation Unit Home Health/DME – discharge from acute setting	344-8111	344-8458
Outpatient services: Outside of the service area or the contracted network Surgery outpatient or elective inpatient	344-8480 344-8480	344-8706 344-8524
Skilled Nursing Facilities	344-8734	344-8348
Rehabilitation	344-8734	344-8348
OB Authorizations/Notifications: Delivery notifications (due on day of delivery) Prenatal care/global OB services	344-8111	344-8458
Pharmacy: Non-Formulary Drug Request Drugs requiring prior authorization Intravenous infusion (IV) non-formulary hydration TPN (total parenteral nutrition)	344-8451	344-8858
Dental: Dental Evaluations	344-8111	344-8458
Dentures	344-8483 344-8825 344-8859	344-8706 344-8524
Supplies/Equipment (DME): Durable Medical Equipment	344-8483 344-8825 344-8859 344-8734	344-8706 344-8524 344-8348
Oxygen	344-8111	344-8458
Prosthetics, Orthotics, Braces	344-8483 344-8825 344-8859	344-8706 344-8524
Home Care Services: Home Health Aid (non-ALTCS) Home Uterine Monitoring	344-8483 344-8825 344-8859	344-8706 344-8524
Home Health Care	344-8734	344-8706
Home Health Nursing	344-8810	344-8706

Prior Authorization cont.

Prior Authorization cont.

Other:		
Allergy consults & testing	344-8483 344-8825 344-8859	344-8706 344-8524
Attendant Care (non-ALTCS)	344-8483 344-8825 344-8859	344-8706 344-8524
Dexa Scans	344-8111	344-8458
Dialysis	344-8111	344-8348
Dialysis-staff assisted only	344-8111	344-8458
Disease Management Programs	344-8310	344-8348
Emergent/Urgent Care Services	344-8111	344-8458
Hospice	344-8483 344-8825 344-8859	344-8706
Infertility	344-8483 344-8825 344-8859	344-8706 344-8524
Transportation/Non emergency ambulance	344-8111	344-8458
Podiatry care in a skilled setting - Non-Medicare	344-8111	344-8458
Podiatry outpatient Care	344-8111	344-8458
Nutritional supplements	344-8483 344-8825 344-8859	344-8706 344-8524
Pain Management	344-8483 344-8825 344-8859	344-8706 344-8524
Seating Evaluations	344-8483 344-8825 344-8859	344-8706 344-8524
Sleep Studies	344-8483 344-8825 344-8859	344-8706 344-8524
Therapies: Pulmonary, Respiratory, Cardiac Rehab, OT, Speech, PT	344-8483 344-8825 344-8859	344-8706 344-8524
Transplants or related care	344-8111	344-8348

Note: Services listed above require prior authorization from MIHS-HP. Services noted as non-ALTCS: when provided to an ALTCS member authorization from MIHS-HP is still required; however, it must be obtained by contacting the member's assigned MIHS-HP case manager.

Prior Authorization cont.

Prior Authorization for Emergent/Urgent Services

Emergency Services are covered inpatient or outpatient services that are:

- Furnished by a provider qualified to provide emergency services; and
- Needed to evaluate or stabilize an emergency medical condition
- Emergencies do not require prior authorization. ***Emergency Services Providers must contact MIHS-HP Authorization Department once the member is stabilized.***

Urgently Needed Services are covered services provided to a member as a result of an unforeseen illness, injury or condition at a time when it was not reasonable to obtain services from MIHS-HP or the member was out of the MIHS-HP service area. The provider of service must contact the Authorization Department and obtain an authorization number. MIHS-HP will instruct the provider to direct the member to his/her PCP for follow up care and instruct the provider to forward all appropriate documents to the PCP for continuity of care.

The MIHS-HP Authorization Department representative will request to following information from a provider requesting authorization:

- Caller's name
- Provider name and ID# (applies to admitting or attending physician and/or surgeon, as applicable)
- Member name and MIHS-HP ID# (AHCCCS, Medicare and/or social security number)
- Type of admission/service
- Admission/surgery service date
- ICD-9 diagnosis code(s), if available
- CPT-4 code(s), if available
- Estimated charges, if known (e.g., capped fee, negotiated rates, percent of billed charges)
- Medical justification – ***all care/services must be medically necessary***
- (*Medically necessary or medical necessity refers to "…those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law to:*
- *Prevent disease, disability, and other adverse health conditions or their progression, or to prolong life." (AZ Admin code R9-2201091 {69})*
- *Medical necessity is also established if:*
- *The disease or condition considered for treatment is one that the effectiveness of the proposed therapy has been demonstrated and documented*
- *The stage of disease or condition is such that therapy can affect the outcome in a positive manner and/or*
- *The recipient of care has no other conditions that substantially reduce the potential for successful recovery*

MIHS-HP Authorization Department will assess the information provided and contact the provider with an approval or denial. If the request is denied, MIHS-HP will issue a denial letter to the provider and the member within three (3) working days after the receipt of all required information. The MIHS-HP Medical Director will review and determine the necessity for a denial.